DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 94-17

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1994

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY 94 $ 3,250,000
b. FFY 95 $ 13,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attached

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attached

10. SUBJECT OF AMENDMENT:
Nursing Facility Methods and Standards for Establishing Payment Rates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Donna L. Whiteman is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Donna L. Whiteman

14. TITLE:
Secretary

15. DATE SUBMITTED:
9-21-94

16. RETURN TO:
Donna L. Whiteman, Secretary
Kansas Department of Social and Rehabilitation Services
Docking State Office Building
915 Harrison, 628-S
Topeka, Kansas 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/27/94

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
7/1/94

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:
cc:
Schalansky
Day
Haverkamp

SPA CONTROL
Date Submitted 9/23/94
Date Received 9/27/94

FORM HCFA-179 (07-92)

Instructions on Back

KANSAS MEDICAID STATE PLAN

Form HCFA-179
State Plan TN-MS-94-17
Attachment 4.19D, Part I
Nursing Facility

Number of Plan Section:	Number of Superseded Plan Section:
Assurance Letter Dated September 22, 1994	Assurance Letter Dated March 29, 1994, TN-MS-94-02
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Subpart A:	Subpart A:
Exhibit A-1, Pages 1-10	Exhibit A-1, Pages 1-10, TN-MS-94-02
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Subpart C:	
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Exhibit C-2, Pages 1-8	Exhibit C-2, Pages 1-5 & 7-9, TN-MS-93-19; Pages 6 & 11, TN-MS-94-02; and Page 10, TN-MS-92-32
Exhibit C-3, Page 1	Exhibit C-3, Page 1, TN-MS-94-02
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Exhibit C-4, Page 1	Exhibit C-4, Pages 1-3, TN-MS-94-02
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JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

September 22, 1994

Mr. Richard P. Brummel
Associate Regional Administrator for the
Division of Medicaid
Room 235, Federal Office Building
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for long term care services in nursing facilities (NFs) and NFs/Mental Health (NFs-MH). The requirements set forth in paragraphs (b) through (i) of this section are being met. The related information required by section 447.255 of this subpart is furnished herewith and the agency complies with all other requirements.

42 CFR 447.253(f) Findings

The State of Kansas, through this agency does make findings to ensure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b).

42 CFR 447.253(b)(1)(i) Payment Rates

The State of Kansas continues to pay nursing facilities (NFs) and NFs-Mental Health (NFs-MH) for long term care services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(iii) Payment Rates

With respect to NF and NF-MH services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the cost of complying with Part 483, Subpart B of Chapter IV;

Refers to MS-94-17.

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) of Chapter IV to provide licensed nurses on a 24-hour bases;

(C) The State of Kansas established procedures under which the data and methodology used in establishing payment rates are made available to the public.

42 CFR 447.253(b)(2) Upper Payment Limits

The State of Kansas assures that the estimated average proposed Medicaid payment is reasonably expected to pay no more in the aggregate for NF and NF-MH services than the amount the agency reasonably estimates would be paid under the Medicare principles of reimbursement. There are no state operated NFs or NFs-MH so 447.272(b) does not apply.

42 CFR 447.253(d) Changes in Ownership of NFs and ICFs-MR

The State of Kansas assures that its NFs and NFs-MH payment methodology is not reasonably expected to result in an increase in aggregate payments based solely as the result of a change in ownership in excess of the increase that would result from application of 447.253(d)(1) and (2).

42 CFR 447.253(e) Provider Appeals

The State of Kansas, in accordance with federal regulations and with the Kansas Administrative Regulations, provides a fair hearing, appeal or exception procedure that allows for an administrative review and appeal by the provider as to their payment rates.

42 CFR 447.253(f) Uniform Cost Reporting

Nursing facilities and NFs-MH providers are required to file annual uniform cost reports in accordance with Kansas Administrative Regulations and Attachment 4.19D, Part I, Methods and Standards for Establishing Payment Rates.

42 CFR 447.253(g) Audit Requirements

The State of Kansas performs a review on all cost reports within six months of receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

42 CFR 447.253(h) Public Notice

In accordance with 42 CFR 447.205, public notice was given for the significant changes proposed to the methods and standards for setting NF and NF-MH payment rates.

Refers to MS-94-17.

42 CFR 447.253(i) Rates Paid

The State of Kansas assures that payment rates are determined in accordance with methods and standards specified in an approved State Plan.

42 CFR 447.255 Related Information

Estimated Average NF/NF-MH Rate:	7/1/94	$60.08
Estimated Average NF/NF-MH Rate:	1/1/94	$56.58
Per Diem Increase		3.50
Average Percent Increase		6.19%

Both the short-term and long-term effect of these changes are estimated to:

1. Maintain the availability of services on a statewide and geographic area basis.

   There are approximately 407 licensed NFs or NFs-MH in the State of Kansas with at least one in every county. Of these, 399 or 98% are certified to participate in the Medicaid Program. There are 16 licensed NFs-MH in the State of Kansas and all of them participate in the Medicaid program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies;

2. Maintain the type of care furnished; and

3. Maintain the extent of provider participation.

   The extent of provider participation should not be affected by this change. Ninety-five percent of the available providers are already participating in the program.

Any questions regarding this Plan submission should be directed to Tina Hayes or Bill McDaniel at (913) 296-3981.

Sincerely,

Donna L. Whiteman

Donna L. Whiteman
Secretary

DLW:RLE:TAH:mas

Refers to MS-94-17

Methods and Standards for Establishing Payment Rates
--Skilled Nursing and Intermediate Care Facility
(Nursing Facilities and Nursing
Facilities for Mental Health)

List of Contents

30-10-1a. Nursing facility program definitions. (a) The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise:

(1) "Accrual basis of accounting" means that revenue of the provider is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(2) "Active treatment for individuals with mental retardation or related condition" means a continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed towards:

(A) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(B) the prevention or deceleration of regression or loss of current optimal functional status.

(3) "Agency" means the department of social and rehabilitation services.

(4) "Ancillary services and other medically necessary services" means those special services or supplies for which charges are made in addition to routine services.

(5) "Case mix" means a measure of the intensity of care and services used by a group of residents in a facility.

(6) "Case mix index" means a numeric score with a specific range that identifies the relative resources used by a particular group of residents and represents the average resource consumption across a population or sample.

(7) "Change of ownership" means a transfer of rights and interests in real and personal property used for nursing facility services through an arms-length transaction between unrelated persons or legal entities.

(8) "Change of provider" means a change of ownership or lessee specified in the provider agreement.

(9) "Common ownership" means an entity holds a minimum of five percent ownership or equity in the provider facility and in the company engaged in business with the provider facility.

(10) "Control" means that an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

(11) "Cost and other accounting information" means adequate data, including source documentation, that is accurate, current, and in sufficient detail to accomplish the purposes for which it is intended. Source documentation, including petty cash pay out memoranda and original invoices, shall be valid only if it originated at the time and near the place of the transaction. In order to provide the required cost data, financial and statistical records shall be maintained in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial

change in accounting procedures when there is a compelling reason to effect a change of procedures.

(12) "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered.

(13) "Costs not related to resident care" means costs which are not appropriate, necessary or proper in developing and maintaining the nursing facility operation and activities. These costs are not allowable in computing reimbursable costs.

(14) "Costs related to resident care" means all necessary and proper costs, arising from arms-length transactions in accordance with general accounting rules, which are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities. Specific items of expense shall be limited pursuant to K.A.R. 30-10-23a, K.A.R. 30-10-23b, K.A.R. 30-10-23c, K.A.R. 30-10-24, K.A.R. 30-10-25, K.A.R. 30-10-26, K.A.R. 30-10-27 and K.A.R. 30-10-28.

(15) "Cost report" means the form MS-2004, nursing facility financial and statistical report.

(16) "Educational activities" means an approved, formally organized or planned program of study usually engaged in by providers in order to enhance the quality of resident care in an institution. These activities shall be licensed when required by state law.

(17) "Educational activities--net cost" means the cost of approved educational activities less any grants, specific donations or reimbursements of tuition.

(18) "General accounting rules" means the generally accepted accounting principles as established by the American institute of certified public accountants, except as otherwise specifically indicated by nursing facility program policies and regulations. Any adoption of these principles shall not supersede any specific regulations and policies of the nursing facility program.

(19) "Hospital-based nursing facility" means a facility that is attached or associated with a hospital. An allocation of expenditures between the hospital and the long-term care facility shall be required through a step-down process.

(20) "Inadequate care" means any act or failure to act which potentially may be physically or emotionally harmful to a recipient.

(21) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function. Relevant diagnoses are limited to schizophrenia, major affective disorders, atypical psychosis, Bipolar disorder, paranoid disorders or schizoaffective disorder.

(22) "Mental retardation" means subaverage general intellectual functioning which originates in the developmental period and which is associated with an impairment in adaptive behavior.

(23) "Non-working owners" means any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the nursing facility.

(24) "Non-working related party or director" means any related party as defined in K.A.R. 30-10-1a who does not perform a resident-related function for the nursing facility.

(25) "Nursing facility (NF)" means a facility which meets state licensure standards and which provides health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(26) "Nursing facility for mental health" means a nursing facility which meets state licensure standards and provides structured mental health rehabilitation services, in addition to health-related care, for individuals with a severe and persistent mental illness who require 24-hours-per-day, seven-days-per-week, licensed nursing supervision and which was operating in accordance with a provider agreement with social and rehabilitation services on June 30, 1994.

(27) "On-going entity" means a change in the provider has not been recognized.

(28) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of business. These costs are intangible assets in that they represent expenditures for

rights and privileges which have value to the enterprise. The services inherent in organization costs extend over more than one accounting period and should be amortized over a period of not less than 60 months from the date of incorporation.

(29) "Owner-related party compensation" means salaries, drawings, consulting fees, or other payments paid to or on behalf of any owner with a five percent or greater interest in the provider or any related party as defined in K.A.R. 30-10-1a, whether the payment is from a sole proprietorship, partnership, corporation, or non-profit organization.

(30) "Ownership" means the person or legal entity that has the rights and interests of the real and personal property used to provide the nursing facility services.

(31) "Plan of care for nursing facilities" means a document which states the need for care, the estimated length of the program, the methodology to be used, and expected results.

(32) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report is based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(33) "Provider" means the operator of the nursing facility specified in the provider agreement.

(34) "Recipient" means a person determined to be eligible for medicaid/medikan services in a nursing facility.

(35) "Related parties" means any relationship between two or more parties in which one party has the ability to influence another party to the transaction such that one or more of the transacting parties might fail to pursue its own separate interests fully or is designed to inflate medicaid/medikan costs. Related parties include parties related by family, business or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arms-length negotiations.

(36) "Related to the nursing facility" means that the facility, to a significant extent, is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(37) "Representative" means a legal guardian, conservator or representative payee as designated by the social security administration, or any person designated in writing by the resident to manage the resident's personal funds, and who is willing to accept the designation.

(38) "Resident assessment form" means the document jointly specified by the Kansas department of health and environment and the agency and approved by the health care finance administration which includes the minimum data set.

(39) A "resident day" means that period of service rendered to a patient or resident between census-taking hours on two successive days and all other days for which the provider receives payment,

either full or partial, for any medicaid/medikan or non-medicaid/ medikan resident who was not in the home. Census-taking hours consist of 24 hours beginning at midnight.

(40) "Routine services and supplies" means services and supplies that are commonly stocked for use by or provided to any resident. They are to be included in the provider's cost report.

(41) "Severe and persistent mental illness" means that an individual:

(A) Meets one of the following criteria:

(i) The individual has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime;

(ii) the individual has experienced a single episode of continuous, structured supportive residential care other than hospitalization for a duration of at least two months; and

(B) meets at least two of the following criteria, on a continuing or intermittent basis, for at least two years:

(i) The individual is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history;

(ii) the individual requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help;

(iii) the individual shows severe inability to establish or maintain a personal social support system;

(iv) the individual requires help in basic living skills; or

(v) the individual exhibits inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

(42) "Specialized mental health rehabilitation services" means one of the specialized rehabilitative services which provides ongoing treatment for mental health problems aimed at attaining or maintaining the highest level of mental and psychosocial well-being. This includes but is not limited to:

(A) Crisis intervention services;

(B) drug therapy or monitoring of drug therapy;

(C) training in medication management;

(D) structured socialization activities to diminish tendencies toward isolation and withdrawal;

(E) development and maintenance of necessary daily living skills, including grooming, personal hygiene, nutrition, health and mental health education, and money management; and

(F) maintenance and development of appropriate personal support networks.

(43) "Specialized services" means inpatient psychiatric care for the treatment of an acute episode of mental illness.

(44) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital or nursing facility with reimbursement based on the specific type of care provided.

(45) "Twenty-four hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered

nurse for at least eight consecutive hours a day, seven days a week.

(46) "Working trial balance" means the summary from the provider's general ledger that was used in completing the cost report.

(b) The effective date of this regulation shall be July 1, 1994. (Authorized by and implementing K.S.A. 39-708c; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994.)

30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, on the basis of the cost information submitted by the provider and retained for cost auditing. The cost information for each provider shall be compared with other providers that are similar in size, scope of service and other relevant factors to determine the allowable per diem cost.

(2) Per diem rates shall be limited by cost centers, except where there are special level of care facilities approved by the United States department of health and human services. The limits shall be determined by the median in each cost center plus a percentage of the median. The percentage factor applied to the median shall be determined by the secretary.

(A) The cost centers shall be as follows:

(i) Administration;

(ii) property;

(iii) room and board; and

(iv) health care.

(B) The property cost center maximum shall consist of the plant operating costs and an adjustment for the real and personal property fees.

(C) The percentile limits shall be determined from an annual array of the most recent historical costs of each provider in the data base.

30-10-18 (2)

(3) To establish a per diem rate for each provider, a factor for incentive, historical inflation, and estimated inflation shall be added to the allowable per diem cost.

(4) Resident days in the rate computation.

(A) Each provider which has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(B) The 85 percent minimum occupancy rule shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider unless the provider is allowed to file a projected cost report.

(C) The minimum occupancy rate shall be determined by multiplying the total licensed beds by 85 percent. In order to participate in the medicaid/medikan program, each nursing facility provider shall obtain proper certification for all licensed beds.

(D) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(5) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(6) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.